STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES

MEDICAID WAIVER, PROVIDER, AND SERVICES CHOICE STATEMENT

INDIVIDUAL NAME	DATE OF BIRTH
MEDICAID NUMBER	DMH ID NUMBER

Choice to Participate in a Division of Developmental Disabilities Waiver
As an alternative to placement in a long term care facility known as an Intermediate Care Facility for Mental Retardation (ICF/MR), you have been recommended for participation in the following Division of Developmental Disabilities Medicaid Home and Community-Based Waiver program:
[ ] Comprehensive Waiver [ ] Community Support Waiver [ ] Sara Jian Lopez Waiver [ ] Autism Waiver
[ ] Partnership for Hope Waiver

You may request services through this Medicaid Home and Community-Based Waiver, or you may request referral to an ICF/MR facility. Please indicate your choice of the following services:

☐ I wish to participate in the Medicaid Home and Community Based Waiver program specified above. I understand that participation is conditional based on my eligibility for Medicaid and other criteria.

☐ I wish to be referred to an ICF/MR facility.

I HAVE RECEIVED INFORMATION REGARDING THE OPTION TO SELF-DIRECT MY SERVICES' AS WELL AS INFORMATION FOR QUALIFIED AGENCY SUPPORTS (SEE ATTACHED FORM) AND SIGN THAT I REVIEWED THE LIST _____ _____
Initials of Responsible Party **Date**

CHOICE OF SERVICE, PROVIDER or SELF-DIRECTED SUPPORTS (SEE ATTACHED FORM)

Service Choice (List all Services)	Name of Provider or Self-Directed chosen from attached list

Additional Choices can be added to Supplemental Page

I CERTIFY THAT I HAVE CHOSEN THE ABOVE SERVICES AND PROGRAMS

_____
Signature of Responsible Party Date

I CERTIFY THAT I HAVE CHOSEN TO SELF-DIRECT MY SERVICES AND/OR HAVE CHOSEN THE ABOVE LISTED QUALIFIED WAIVER SERVICES PROVIDERS (IF APPLICABLE)

_____ _____ Not Applicable
Signature of Responsible Party Date

DISTRIBUTION: Copy for the INDIVIDUAL/PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE and copy for TCM Provider

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
MEDICAID WAIVER, PROVIDER, AND SERVICES CHOICE STATEMENT
(Supplemental Page)

INDIVIDUAL NAME	DMH ID

CHOICE OF SERVICE, PROVIDER or SELF-DIRECTED SUPPORTS

This page is used only when:

1) *Additional space is needed to list service choices in new waiver or*
2) *When the individual, guardian and/or designated representative choose a new service and/ or new provider (changes providers) and/or choose to start self-directing supports*

[ ] 1) Supplemental Page for Initial enrollment of waiver

[ ] 2) Supplemental Page for change of service or provider, or change to self-directed supports
Effective date:

I HAVE RECEIVED INFORMATION REGARDING THE OPTION TO SELF-DIRECT MY SERVICES' AS WELL AS INFORMATION FOR QUALIFIED AGENCY SUPPORTS (SEE ATTACHED FORM) AND SIGN THAT I REVIEWED THE LIST _____ _____
Initials of Responsible Party **Date**

CHOICE OF SERVICE, PROVIDER or SELF-DIRECTED SUPPORTS (SEE ATTACHED FORM)

Service Choice (List all Services)	Name of Provider or Self-Directed chosen from attached list

I CERTIFY THAT I HAVE CHOSEN THE ABOVE SERVICES

_____
Signature of Responsible Party Date

I CERTIFY THAT I HAVE CHOSEN TO SELF-DIRECT MY SERVICES AND/OR HAVE CHOSEN THE ABOVE LISTED QUALIFIED WAIVER SERVICES PROVIDERS (IF APPLICABLE)

_____ _____ Not Applicable
Signature of Responsible Party Date

DISTRIBUTION: Copy for the INDIVIDUAL/PARENT/GUARDIAN/DESIGNATED REPRESENTATIVE and copy for TCM Provider